State of Hawaii
Health Department

Public Health
Nursing Branch

REQUEST FOR NURSING SERVICES

DATE:_____

CLIENT: _____ SEX:___ BD:___/___/___ School / Gr:_____
Last First

_____ SEX:___ BD:___/___/___ School / Gr: _____

_____ SEX:___ BD:___/___/___ School / Gr: _____

ADDRESS: _____ **APT. NO**._____ **HOME PHONE:** _____

Mailing address (if different): _____

FATHER: _____ BD:___/___/___ Phone:_____
(Man) Last First if different work
other

MOTHER: _____ BD:___/___/___ Phone:_____
(Woman) Last First if different work
other

Other Contact Person / Phone: _____

MEDICAL INSURANCE & NUMBER: _____

PHYSICIAN / PCP: _____

Medical/Clinical Diagnosis:_____

REASON(S) FOR REFERRAL _____

_____

_____

SIGNIFICANT INFORMATION _____

_____

_____

_____

_____

PLANNED DISCHARGE DATE: _____ HOSPITAL: _____

OTHER AGENCIES INVOLVED OR REFERRED TO: CONTACT PERSON & PHONE NUMBER:

_____ _____

_____ _____

REQUESTED BY: _____ Title: _____ Agency: _____

ADDRESS: _____ **Phone:** _____

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PHN SUMMARY:_____

_____

_____

_____

For PHN Office Use Only:
Date Rcvd: _____ By: _____ CT /Assigned PHN: _____

Currently Carried ☐ No ☐ Yes By_____Previously Carried by_____Registration#_____
QA_____ Live_____

DISPOSITION: ☐ Admitted ☐ Disposition Letter Sent; Date_____ Not admitted date:_____
☐ L Unlocated ☐ R Refused PHN services ☐ C Assistance from Other Agency/Program ☐_____

PHN 10R – Rev 11/2003